

Case Number:	CM14-0033713		
Date Assigned:	08/25/2014	Date of Injury:	06/12/2000
Decision Date:	09/29/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/11/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 59-year-old, female who sustained a vocational injury on June 12, 2000. There are no office notes or provider notes identifying subjective complaints, abnormal physical exam objective findings; there are also no reports from the diagnostic studies available for review. A Peer Review report dated 02/18/14 documented current diagnoses of right shoulder rotator cuff sprain, right shoulder disorder, and bilateral brachial neuritis. The Peer Review report documented that the claimant had been seen by her provider on 02/10/14 with bilateral upper extremity and trapzii pain, right worse than left and that previous injections only provided temporary relief. The Peer review report documented that an MRI, date not known, was interpreted by the claimant's provider as showing severe subacromial impingement. The formal report was not provided for the Peer review. The Peer review report did not recommend the medical necessity for right shoulder arthroscopy, subacromial decompression and possible rotator cuff repair due to a lack of diagnostic imaging corroborating pathology that would be amenable to surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right Shoulder Arthroscopy SAD possible Right cuff repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery - Acromioplasty: Surgery for impingement syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-211.

Decision rationale: Based on the California ACOEM Guidelines, the request for Right Shoulder Arthroscopy, SAD, and possible Right cuff repair cannot be recommended as medically necessary. The ACOEM Guidelines for surgical indications require clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Due to the fact that there are no medical records available for review establishing significant subjective complaints and abnormal objective findings on examination that corroborate with diagnostic studies confirming pathology, the proposed right shoulder arthroscopy, subacromial decompression, and possible rotator cuff repair cannot be considered medically necessary.

Post op PT 3x4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The request for Right Shoulder Arthroscopy, SAD, and possible right cuff repair cannot be recommended as medically necessary. Therefore, the request for postoperative physical therapy is also not recommended as medically necessary.

Post op polar unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);
Shoulder chapter - Continuous Cold therapy.

Decision rationale: The request for Right Shoulder Arthroscopy, SAD, and possible Right cuff repair cannot be recommended as medically necessary. Therefore, the request for a postop polar unit purchase cannot be considered medically necessary.

Abduction sling purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Shoulder chapter - Post-op Abduction Sling.

Decision rationale: The request for Right Shoulder Arthroscopy, SAD, and possible Right cuff repair cannot be recommended as medically necessary. Therefore, the request for an abduction sling purchase cannot be considered medically necessary.

CPM rental x 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter - Continuous passive Motion.

Decision rationale: The request for Right Shoulder Arthroscopy, SAD, and possible Right cuff repair cannot be recommended as medically necessary. Therefore, the request for a continuous passive motion rental machine times 21 days cannot be considered medically necessary.